COORDINATION OF BENEFIT COVERAGE QUESTIONNAIRE

To fax completed form: 316-616-6151 ● To call for service: 866-827-6607

To mail completed form: LIFESTYLE HEALTH PLANS ● 345 N. RIVERVIEW STE 600 ● WICHITA, KS 67203

The coordination of benefits is the verification of other insurance coverage on yourself and/or your dependents so we can accurately coordinate benefit payments with primary and/or secondary payors for you, based on the rules detailed in the plan. We request this information at least every 12 months. Please provide information regarding any other insurance coverage you currently have.

EMPLOYER INFORMATION (please print)

Employer name		Group number (and division number, if applicable)		
Employer's street address	City	St	Zip	Phone

EMPLOYEE INFORMATION (please print)

First name	Last		MI	Social Security Number	Date of birth
Street address	City	St	Zip	Phone	Date of hire

Gender	Marital Status			
○ Male ○ Female	○ Single	○ Married	○ Widowed	○ Divorced

Spouse's name	Spouse's date of birth	Spouse's employer		
Spouse's employer street address	City	St	Zip	Employer's phone	# of children (under 19):

Do you have children residing with you covered by this plan? If so, please provide the following information:

Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth

Does any covered member or dependent have other insurance coverage? ○ Yes ○ No If yes, complete the following:

Does your spouse carry any other insurance coverage through current employer? ○ Yes ○ No

If yes please select the type and level of coverage that your spouse carries:

Group Medical	○ Employee only	○ Employee & spouse	○ Employee/family	○ Employee/child(ren)	○ No coverage
Dental	○ Employee only	○ Employee & spouse	○ Employee/family	○ Employee/child(ren)	○ No coverage
Cancer	○ Employee only	○ Employee & spouse	○ Employee/family	○ Employee/child(ren)	○ No coverage
Other	○ Employee only	○ Employee & spouse	○ Employee/family	○ Employee/child(ren)	○ No coverage

Are you required by court order to provide insurance for your ex-spouse? ○ Yes ○ No

If so, please provide ex-spouse's information:

Ex-spouse's first name	Last	MI	Social Security Number	Date of birth

Street address	City	St	Zip	Phone	Gender ○ Male ○ Female

Do you have to provide coverage for children resulting from a court order such as divorce? ○ Yes ○ No

If so, and they do not reside with you for more than 6 months of the year, please provide the following information:

Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth

Which parent was awarded financial responsibility for the medical/dental expenses of the dependent? ○ You ○ Ex ○ Both

If no court decree was issued, which parent has physical custody of the dependent(s)? ○ You ○ Ex ○ Both

Is the ex-spouse remarried? ○ Yes ○ No

Does a step-parent carry the dependent(s) under own insurance? ○ Yes ○ No

If yes, please provide the name and address of the step-parent and their employer and insurance carrier:

Step-parent's first name	Last	MI	Step-parent's date of birth

Step-parent's employer street address	City	St	Zip	Name of step-parent's carrier

Insurance carrier's name	Insurance carrier's group number

Insurance carrier's street address	City	St	Zip	Insurance carrier's phone

Are you or any of your dependents covered under an individual policy not obtained through an employer? ○ Yes ○ No
If so, please provide carrier's contact information below:

Insurance carrier's name	Insurance carrier's group number

Insurance carrier's street address	City	St	Zip	Insurance carrier's phone

Are you or any of your dependents eligible for Medicare? ○ Yes ○ No

If so, please list those with Medicare coverage:

Effective Date of Medicare Part A: _____/ ______/ _______

Effective Date of Medicare Part B: _____/ ______/ _______

If you or your family member have Medicare and are under the age of 65, please indicate the reason for eligibility

I confirm the above information is accurate and current:

Employee signature	Date

Thank you. Please notify us if this information changes within the next 12 months, including any change of address. Use the contact information at the top of this form if you have questions.